PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME _____ PHONE (home) _____

PATIENT ADDRESS _____ (work) _____

NAME OF PRIMARY CARE PHYSICIAN _____

If in a Group Practice, Name of Group _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S PHONE _____

Other Physicians from whom you receive care _____

DATE OF LAST COMPLETE PHYSICAL _____

A. MEDICATIONS

1. Please list **all** medications you are currently taking, prescription and over the counter.

NAME OF DRUG	DOSE	PRESCRIBED BY

2. Are you allergic to Peniciliin or other drugs? _____

3. Have you had any side effects or serious reactions to any medication or over the counter preparations?

_____

B. PAST MEDICAL HISTORY

1. Please list any hospitalizations, operations, accidents, or serious illnesses or patient.

DATE	NATURE OF ACCIDENT, OPERATION, HOSPITALIZATION	DOCTOR'S NAME

2. Have you or any of your blood relatives had any of the following:

PATIENT	RELATIVE	
		Bleeding disorders
		Diabetes/Thyroid problems
		Heart/Breathing problems
		High Blood Pressure
		Kidney, Liver, or Intestinal disorders
		Joint or Muscle Problems
		Headaches or Neck Pain
		Stroke
		Cancer
		Serious Infections
		Epilepsy or other Nervous problems
		Mental or Emotional problems
		History of Suicide Attempt

C. LIFESTYLE

1. Do you smoke? No (cigarettes, cigars, pipes)

   How much and for how long? _____

2. Do you drink alcohol? No How much and how often? _____

3. Do you use any drugs such as marijuana, cocaine, etc.? _____

4. Do you consume caffeine? No How much per day? _____

5. Do you obtain any regular exercise? _____

D. FOR CHILDREN

1. Are all immunizations current? Yes If not, do you need assistance in obtaining immunizations? No

_____
Signature of Person Completing Form

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1. ☐ Patient has had a physical examination within the last year and does not require somatic follow-up.
2. ☐ Patient has not had a physical examination within the last year for the following reason:

   _____

   a. ☐ Physical examination requirement has been waived for the following reason:

   _____

   b. ☐ Physical examination recommended.

_____ _____
Signature of **Physician** reviewing information Date